Workers' Compensation Guidelines
And
Workers' Compensation Anti-Fraud Plan

Employee Acceptance Form

It is mandatory that this form be signed, dated and returned to the employee's immediate supervisor to be forwarded to Risk Management.
A copy of this signed form is to be kept at the location of employment.

I have read or had read to me the Workers' Compensation Guidelines for Williamson County Government, Williamson County School System and Williamson County Volunteer Firefighters.

I have read or had read to me the Williamson County, Tennessee Workers' Compensation Anti-Fraud Plan.

I understand that it is a crime to provide false, incomplete or misleading information to any party to a workers compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

I understand that if possible I should notify my supervisor immediately in the event of a job related injury or illness. Work related injuries or illness must be reported within 30 days. I understand that I must sign all appropriate forms.

I understand that I must choose one of the authorized physicians or seek medical treatment at the named medical facility in the event I am injured or contract an illness due to a work related incident.

I further understand the importance of an injury or illness as a result of a job related incident and understand that if I seek medical treatment or attention from any physician or facility other than those authorized, and/or do not follow the treatment prescribed by said physician and/or physical therapist I will become responsible for the payment of my own medical bills.

_____
Employee Name Printed

_____
Employee Name Signed

_____
Location / Department

_____
Date